# WEST VIRGINIA INSURANCE COMMISSION

## REVIEW REQUIREMENTS CHECKLIST

## GROUP ACCIDENT & SICKNESS INSURANCE

| REVIEW REQUIREMENTS | REFERENCE | COMMENTS |
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| **FORMS** | | |
| **GENERAL REQUIREMENTS** | | |
| **Fees** | §33-6-34 | The fee for a Form Filing is $50.00. Fee Revisions are Effective 6/30/2002. |
| **Inclusions** | Informational Letter No 17 | Include in the submission: One copy of the forms being filed; One cover letter; One Return Copy of the Cover Letter; The Form Filing Abstract, ASA-F-2003 ; A Certificate of Readability (Flesch Score); A Certificate of Compliance; One copy of the Forms submitted for review ; A self-addressed, pre-paid label or large envelope; The appropriate Filing Fee. |
| | §33-3-7 | The company transacting insurance in this State must be licensed by the Insurance Commissioner and authorized to conduct the appropriate lines of business for the filing submitted. |
| **Certifications** | | |
| Readability | §33-29-5 (a)(1) | The Certification of Readability must show a Test Score of 40 or better according to the Flesch Score reading ease Method or by any other comparable method. |
| Compliance | §33-16 | Group Accident and Sickness policy forms must comply with Chapter 16 of the WV Code. The Required provisions are found in 33-16-3. |
| | §33-16A | Group Health – Conversions: This Chapter sets forth the requirements for group policy conversions. |
| | §114-10 | Advertising |
| | §114-24 | Medicare Supplements |
| | §114-26 | Rate Filing Accident and Sickness |
| | §114-27 | AIDS Regulation |
| | §114-28 | Coordination of Benefits |
| | §114-29 | Temporo/Craniomandibular Disorders |
| **Applications** | | |
| | | The Application, when attached to the policy, and all its attachments become part of the Entire Contract. Statements are binding only if an application is attached. Only the applicant can alter statements on the application. This Division does not permit a box on the Application, **For Company Use Only**, because no changes are to be made to the Entire Contract after the application has been signed by the applicant. False statements may bar recovery. |
| **General Characteristics** | | |
| Group Acceptance | | Acceptance of all members of the group, regardless of any individual's physical condition. |
| Master Contract | | Issuance of a master contract to the administrator of the group and individual certificates of insurance (outlines of coverage) to the members. |
| Coordination of Benefits | | Coordination of benefits with other available coverages (such as workers compensation benefits) |
| Conversion Clause | | Permits an individual insured under the group plan to convert to individual coverage upon termination of employment or membership in the group (usually within 31 days of termination). The individual must have participated in the group plan for a given period of time before the conversion privilege applies. |
| Benefits | | Benefits are automatically determined by some preset formula which excludes individual benefit selection and thereby precludes adverse selection by not allowing poor risks to purchase higher amounts of insurance. |

| Legal Requirements | | |
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| Eligible Groups | §33-16-2 | Group policies must come within any of the following classifications:<br>A. The policy is issued to an employer (the policyholder), must insure at least ten employees of the employer, for the benefit of persons other than the employer, and must conform to the following:<br>1. If the premium is paid by the employer, the group shall comprise all employees or all of any class or classes thereof determined by conditions pertaining to the employment.<br>2. If the premium is paid by the employer and employees jointly or by the employees, the group shall comprise not less than seventy percent of all employees of the employer or not less than seventy-five percent of all employees of any class or classes thereof determined by conditions pertaining to the employment.<br>3. The term employee shall be deemed to include the officers, managers, and employees of the employer, the partners, if the employer is a partnership, the officers, managers, and employees of subsidiary or affiliated corporations of a corporation employer, and the individual proprietors, partners and employees of individuals and firms, the business of which is controlled by the insured employer through stock ownership, contract, or otherwise. The term "employer" may be deemed to include any municipal or governmental corporation, unit, agency or department thereof and the proper officers, as such, of any unincorporated municipality or department thereof, as well as private individuals, partnerships and corporations.<br><br>B. The policy is issued to an association which has a constitution and bylaws and has been organized and is maintained in good faith for purposes other than obtaining insurance, insuring at least ten members of the association for the benefit of persons other than the association or its officers or trustees.<br><br>C. The policy is issued to a college, school or other learning institution or to the head or principal and insures at least ten students, or students and employees.<br><br>D. The policy is issued to or in the name of a volunteer fire department, insuring all of the members of such department or all of any class or classes, against any one or more of the hazards to which they are exposed by such membership, but in each case not less than ten such members.<br><br>E. The policy is issued to any person or organization to which a policy of group life insurance may be issued or delivered in this state, to insure any class or classes of individuals that could be insured under such group life policy. |
| **REQUIRED POLICY PROVISIONS** | | Group policies must contain the following: |
| Entire Contract | §33-16-3(a) | A provision that the policy, application of the policyholder, and the individual applications submitted shall constitute the entire contract between the parties, and that all statements made by any applicant(s) shall be deemed representations and not warranties, and that no such statement shall void the insurance or reduce benefits thereunder unless contained in a written application. |
| Individual Certificates | §33-16-3(b) | A provision that the insurer will provide an individual certificate for each member of the group setting forth in substance the essential features of the coverage and to whom benefits are payable. If dependents are included, only one certificate need be issued for each family unit. |
| New Members | §33-16-3(c) | A provision that all new employees or members, in the groups or classes eligible for insurance, shall from time to time be added to such groups or classes eligible to obtain such insurance in accordance with the terms of the policy. |
| Prohibited Provisions | §33-16-3(d) | No provision relative to notice or proof of loss or the time for paying benefits or the time within which suit may be brought upon the policy shall be less favorable to the insured than would be permitted in the case of an individual policy by the provisions set forth in §§33-15-1 et seq. |
| Layoff Provision | §33-16-3(e) | A provision that all members shall be permitted to pay the premiums at the same group rate and receive the same coverages for a period not to exceed 18 months when they are involuntarily laid off from work. |
| Other Provisions | §33-16-3(f) | Further provisions as the commissioner shall promulgate by rule. |

| SPECIAL COVERAGES | | |
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| Mental Health | §33-16-3a | Any group policy shall make available as benefits if so elected by the subscriber or group for expenses arising from mental or nervous conditions as follows. Such benefits shall be as described in the standard nomenclature of the American psychiatric association which are at least equal to the following minimum requirements:<br>a. The period of confinement in a mental hospital for which benefits are payable shall be at least 45 days in any calendar year.<br>b. Benefits based upon confinement as an inpatient in a licensed or accredited general hospital shall be no different than for any other illness.<br>c. In the case of outpatient benefits, these shall cover fifty percent of eligible expenses up to $500 over a 12-month period, services furnished:<br>1. By a comprehensive health service organization;<br>2. By a licensed or accredited hospital;<br>3. Subject to the approval of the department of mental health, services furnished by a community mental health center or other mental health clinic or day care center which furnishes mental health services; or<br>4. Consultations or diagnostic or treatment sessions, provided that such services are rendered by a psychotherapist or by a psychologist and do not exceed fifty such sessions over a twelve-month period.<br>d. Mental health benefits furnished to an enrollee of a plan offered in connection with a group health plan:<br>1. Aggregate Lifetime Limits:<br>A. If the health benefit plan does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the plan may not impose any aggregate lifetime limit on mental health benefits.<br>B. If the plan limits the total amount that may be paid with respect to an individual (or other coverage unit) for substantially all medical and surgical benefits, the plan shall either apply the applicable lifetime limit to medical and surgical benefits and to mental health benefits or not include any aggregate lifetime limit on mental health benefits that is less than the applicable lifetime limit.<br>2. Annual Limits:<br>A. If a plan does not include an annual limit on substantially all medical and surgical benefits, the plan may not impose any annual limit on mental health benefits.<br>B. If the plan places an annual limit on the amount paid with respect to an individual (or other coverage unit) for substantially all medical and surgical benefits, the plan shall either apply the applicable annual limit to medical and surgical benefits and to mental health benefits or not include any annual limit on mental health benefits that is less than the applicable annual limit. |
| Home Health Care Coverage | §33-16-3b | Any insurer who delivers or issues for delivery in West Virginia group basic hospital expense or major medical expense coverage shall make available to the policyholder home health care coverage consistent with the provisions of this section.<br><br>Home health care coverage offered shall include:<br>1. Services provided by a registered nurse or a licensed practical nurse.<br>2. Health services provided by a physical, occupational, respiratory and speech therapists.<br>3. Health services provided by a home health aide to the extent that such services would be covered if provided on an inpatient basis.<br>4. Medical supplies, drugs, medicines and laboratory services to the extent that they would be covered if provided on an inpatient basis.<br>5. Services provided by a licensed midwife or a licensed nurse midwife.<br><br>Home health care coverage may be limited to:<br>1. Services provided on the written order of a licensed physician, provided such order is renewed at least every sixty days.<br>2. Services provided by a home health agency certified in the state in which the services are rendered or under Title XVIII [42 U.S.C. §§ 1395 et seq.] of the Social Security Act.<br>3. Services as set forth above without which the insured would have to be hospitalized. |

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| | | Coverage shall be provided for at least 100 home visits per insured per policy year, with each home visit by a member of a home health care team to be considered as one visit including up to four hours of home health care services.<br><br>No such policy need provide such coverage to persons eligible for Medicare. |
| Alcoholic Treatment Coverage | §33-16-3c | Group, blanket, franchise and association accident and sickness policies must, at the option of the policyholder or sponsor, provide the level of benefits specified below to any insured, subscriber, or other person covered under the policy for expenses incurred in connection with the treatment of alcoholism prescribed by a licensed physician, subject to the right of the policyholder or sponsor to select any alternative level of benefits as may be offered by the insurer or service corporation.<br><br>Benefits provided shall include a minimum of thirty days of inpatient confinement. If inpatient hospital benefits are provided beyond 30 days of confinement, durational limits, dollar limits, deductibles and co-insurance factors applicable thereto need not be the same as applicable to physical illness generally.<br><br>As to outpatient benefits, the co-insurance factor may not exceed 50% of the co-insurance factor applicable for physical generally, whichever is greater, and the maximum benefit for alcoholism in the aggregate during any applicable benefit period may be limited to not less than $750.00. Maximum lifetime benefits may be no less than an amount equal to the lesser of $10,000 or 25% of the lifetime policy limit. |
| Medicare Supplement Insurance | §33-16-3d, §114-24-5, §114-24-6 | Standards for Medicare Supplement Insurance are found in §33-16-3d, §114-24-5, and §114-24-6. |
| Policies to Cover Nursing Services | §33-16-3e | Group policies must make available as benefits coverage for primary health care nursing services if such services are currently being reimbursed when rendered by any other duly licensed health care practitioner. No insurer may be required to pay for duplicative health care services actually provided by both a nurse and other health providers. |
| TMD/CMD | §33-16-3f, §114-29-4 | All accident and sickness coverage which provides hospital, surgical, or major medical coverage must provide benefits for the diagnosis and treatment of temporomandibular disorders (TMD) and craniomandibular disorders (CMD). |
| Mammograms and Pap Smears | §33-16-3g | Whenever reimbursement or indemnity for laboratory or X-ray services are covered, reimbursement or indemnification shall not be denied for mammograms or pap smears when performed for cancer screening or diagnostic purposes, at the direction of a person licensed to practice medicine and surgery by the board of medicine. |
| Rehabilitation Services | §33-16-3h | Insurers shall provide as benefits coverage for rehabilitation services (as defined in §33-16-3h), unless rejected by the insured. |
| Emergency Services | §33-16-3l | Insurers shall provide as benefits coverage for emergency services. A policy, provision, contract, plan or agreement may apply to emergency services the same deductibles, coinsurance and other limitations ass apply to other covered services, provided that preauthorization or precertification shall not be required.<br>Every insurer shall provide coverage for emergency medical services to the extent necessary to screen and to stabilize an emergency medical condition. The insurer shall not require prior authorization of the screening services if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. Prior authorization of coverage shall not be required for stabilization if an emergency medical condition exists. Payment of claims for emergency services shall be based on the retrospective review of the presenting history and symptoms of the covered person.<br>An insurer that has given prior authorization for emergency services shall cover the services and shall not retract the authorization after the services have been provided unless the authorization was based on a material misrepresentation.<br>Coverage of emergency services shall be subject to coinsurance, copayments and deductibles applicable under the health benefit plan.<br>The emergency department and the insurer shall make a good faith effort to communicate with each other in a timely fashion to expedite postevaluation or poststabilization services in order to avoid material deterioration of the covered person's condition. |
| Colorectal Cancer Examination and Laboratory Testing | §33-16-3o | Reimbursement or indemnification for colorectal cancer examinations and laboratory testing may not be denied for any nonsymptomatic person 50 years of age or older, or a symptomatic person under 50 years of age, when reimbursement or indemnity for laboratory or X-ray services are covered under the policy and are performed for colorectal cancer screening or diagnostic purposes at the direction of a person licensed to practice medicine and surgery. |
| AIDS Regulation | §33-16-9, §114-27 | No insurer may cancel or nonrenew a policy of any insured because of diagnosis or treatment of acquired immune deficiency syndrome. See West Virginia Regulation §114-27 for more details. |
| Newly Born Children | §33-6-32 | All health insurance policies shall provide that the health insurance benefits applicable for children shall be payable with respect to a newly born child of the insured or subscriber from the moment of birth. The coverage for newly born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of birth of a newly born child and payment of the required premium or fees must be furnished to the insurer within 31 days |

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| | | after the date of birth in order to have the coverage continue beyond such 31 day period. |
| Child Immunization Services Coverage | §33-16-12 | All policies shall cover the cost of child immunization services as described in W. Va. Code §16-3-5, including the cost of the vaccine, if incurred by the health care provider, and all costs of vaccine administration. These services shall be exempt from any deductible, per-visit charge and/or copayment provisions which may be in force in these policies or contracts. This does not require that other health care services provided at the time of immunization be exempt from any deductible and/or copayment provisions. |
| Diabetes Coverage | §33-16-16 | Except as provided in W. Va. Code §33-15-6, any policy shall include coverage for equipment and supplies listed in W. Va. Code §33-16-16(a) for treatment and/or management of diabetes for both insulin dependent and noninsulin dependent persons with diabetes and those with gestational diabetes, if medically necessary and prescribed by a licensed physician.<br>All policies shall also include coverage for diabetes self-management education to ensure that persons with diabetes are educated as toe the proper self-management and treatment of their diabetes, including information on proper diets. Coverage for this education shall be limited to visits medically necessary upon diagnosis, visits under circumstances whereby a physician diagnoses a significant change in symptoms or conditions that necessitate changes in self-management, and where a new medication or therapeutic process has been identified as medically necessary by a licensed physician.<br>The education may be provided by the physician as part of an office visit, or by a certified diabetes educator certified by a national diabetes educator certification program, or registered dietitian registered by a nationally recognized professional association of dietitians upon the referral of a physician. Provided that such national program has been certified to the commissioner by the commissioner of the bureau of public health.<br>Any deductible or coinsurance billed for any service shall apply on an equal basis with all other coverages provided by the insurer. |
| **Conversion Privileges** | | |
| Right to Convert | §33-16A-1 | A group policy or group subscriber contract which provides hospital, surgical or major medical expense insurance, or any combination of these, on an expense incurred basis, but not a policy which provides benefits for specific diseases or for accidental injuries only, shall provide that an employee or member whose insurance under the group policy or contract has been terminated for any reason, who has been continuously insured under the policy, or under any group policy providing similar benefits which it replaces, for at least three months immediately prior to termination, shall be entitled to have issued to him by the insurer a converted policy of health insurance. An employee or member is not entitled to this if termination occurred due to nonpayment, or the discontinued group coverage was replaced by similar group coverage within 31 days. |
| Standards for Converted Policies | §33-16A-3<br>§33-16A-4<br><br>§33-16A-8<br><br><br>§33-16A-2(b) | The following are standards for converted policies:<br>1. The converted policy must become effective upon termination of insurance coverage under the group policy.<br>2. The converted policy must cover the employee or member or his dependents, or both, who are covered by the group policy on the date of termination of insurance. At the option of the insurer, a separate converted policy may be issued to cover any dependent.<br>3. The converted policy may not contain exclusions for preexisting conditions, except to the extent that a condition was excluded from the group policy from which conversion was made. Benefits for pregnancy and childbirth may not be excluded from the converted policy if benefits for these conditions were provided under the group policy.<br>4. The converted policy must be offered without evidence of insurability. |
| Issuance of Converted Policy | §33-16A-2 | Issuance of a converted policy shall be subject to the following conditions:<br>1. Written application for the converted policy shall be made and the first premium paid to the insurer not later than 31 days after termination.<br>2. The initial premium for the first 12 months and subsequent renewal premiums shall be determined in accordance with premium rates applicable to individually underwritten standard risks, to the age and class of risk of each person to be covered under the converted policy and to the type and amount of insurance provided. The experience under converted policies shall not be an acceptable basis for establishing rates.<br>If an insurer experiences or incurs losses for a period of two years on conversion policies which exceed earned premiums by more than 20%, the insurer may file with the commissioner amended renewal rates which will produce a loss ratio of not less than 120%.<br>Conditions pertaining to health shall not be an acceptable basis for classification. The frequency of premium payment shall be the frequency customarily required by the insurer for the policy form and plan selected, provided that the insurer shall not require premium payments less frequently than quarterly. |

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| **Coordination of Benefits** | | |
| COB Contract Provision | §114-28-3.1 | Appendix A of §114-28 contains a model COB provision. |
| Flexibility | §114-28-3.2 | A group contract's COB provision does not have to use the words and format of the model. Changes may be made to fit the language and style of the rest of the group contract or to reflect the difference amount plans which provide services, which pay benefits for expenses incurred, and which indemnify. No other substantive changes are allowed. |
| **Cost Containment Provisions** | | |
| Mandatory Second Surgical Opinion | | Company won't pay 100% of scheduled charges unless another physician's opinion is sought – emergencies excepted. |
| Pre-Admission Certification | | Company approves the admission to the hospital (emergencies excepted). |
| Concurrent Review | | A review of an insured's medical care while that care is being administered. The purpose of concurrent review is to assure that the required care is being provided. |
| Retrospective Review | | Company reviews all charges by the hospital and the physician and looks for duplicate or unreasonable fees. |
| Ambulatory Outpatient Services | | Deductible waived and at 100%. |
| **COBRA** | | |
| Basic Requirements | | The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) requires employers with 20 employees or more on at least 50% or the working days in the previous calendar year to provide for continuation of health coverage at group rates (except group disability income benefits) for the dependents of all eligible employees with evidence of insurability. |
| | | 1. Qualified beneficiaries may elect to continue coverage identical to that covered under the original health plan.<br>2. Employers have an obligation to determine the specific rights of the beneficiaries and inform them of same through an initial general notice known as a summary plan description.<br>3. Employers must notify plan administrators within 30 days of an employee's death, termination, reduced hours, and/or Medicare entitlement.<br>4. Multi-employer plans may be given a longer period of time than 30 days.<br>5. Employees, retirees and family members must notify the plan administrator within 60 days of such qualifying events as divorce or legal separation or an individual losing "dependent child" status.<br>6. Once notified of a "qualifying event," plan administrators must notify employees and/or family members of their rights to elect benefits identical to those received immediately before the qualifying event.<br>7. Qualified beneficiaries have a 60 day period to elect whether or not to continue coverage.<br>8. Employer Penalties – Employers who fail to comply with COBRA regulations are subject to a fine of $100 per day per eligible insured.<br>9. Premiums – COBRA allows employers to change those who elect to continue coverage 102% of the premiums the employer (company) pays for each employee. The excess 2% covers administrative duties and paperwork required of the employer. A grace period exists for the failure to pay premiums. The grace period is the longest of 30 days, the period the plan allows employees for failure to pay premiums, and the period the insurance company allows the plan or the employer for failure to pay premiums. |